

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>390035</b>	(X2) MULTIPLE CONSTRUCTION:  A. BLDG: <u>00</u> B. WING: _____		(X3) DATE SURVEY COMPLETED:  <b>07/24/2023</b>
NAME OF PROVIDER OR SUPPLIER: <b>ST. LUKE'S HOSPITAL - UPPER BUCKS CAMPUS</b>  STATE LICENSE NUMBER: <b>170301</b>			STREET ADDRESS, CITY, STATE, ZIP CODE: <b>3000 ST. LUKE'S DRIVE QUAKERTOWN, PA 18951</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE	
P 0000	<p>INITIAL COMMENT</p> <p>This report is for the new service, telemedicine-telenephrology, beginning on July 24, 2023. The St. Luke's Hospital-Upper Bucks Campus and St. Luke's Hospital -Quakertown Campus attested they were in full compliance with the requirements of the Pennsylvania Department of Health's Rules and Regulations for Hospitals, 28 PA Code, Part IV, Subparts A and B, November 1987, as amended June 1998.</p>	P 0000			

(X6) DATE:



# Certified End Page

**ST. LUKE'S HOSPITAL - UPPER BUCKS CAMPUS**

**STATE LICENSE NUMBER: 170301**

**SURVEY EXIT DATE: 07/24/2023**

**I Certify This Document to be a True and Correct Statement of Deficiencies and  
Approved Facility Plan of Correction for the Above-Identified Facility Survey**

A handwritten signature in black ink that reads "Jeane Parisi".

*Jeane Parisi*  
*Deputy Secretary for Quality Assurance*

A handwritten signature in black ink that reads "Debra L. Bogen MD".

*Debra L. Bogen, MD, FAAP*  
*Acting Secretary of Health*



THIS IS A CERTIFICATION PAGE

**PLEASE DO NOT DETACH**

THIS PAGE IS NOW PART OF THIS SURVEY